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IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
IN AND FOR DADE COUNTY, FLORIDA
CASE NO. 94-08273 CA (20)

HOWARD A. ENGLE, M.D., et al,

Plaintiffs,

vs.

RJ REYNOLDS TOBACCO COMPANY, et al,

Defendants.
_____/

TELEPHONIC DEPOSITION OF: WILLIAM A. ALONSO, M.D.

TAKEN: Pursuant to Notice by Counsel for Plaintiffs

DATE AND TIME: December 30, 1997; 1:37 p.m.

PLACE: Akerman, Senterfitt & Eidson
100 South Ashley Drive
Suite 1500
Tampa, Florida

BEFORE: TAMMY J. MILCOWITZ, RMR
Notary Public
State of Florida at Large

* Record clear
* Record condensed

APPEARANCES:

JOHN HOAG, ESQUIRE
Stanley M. Rosenblatt, P.A.
66 West Flagler Street
12th Floor, Concord Building
Miami, Florida 33130
Attorney for Plaintiffs
Appearing Via Telephone

CURTIS L. PERRY, ESQUIRE
Shook, Hardy & Bacon, L.L.P.
One Kansas City Place
1200 Main Street
Kansas City, Missouri 64105
Attorney for Defendant
Lorillard Tobacco Company

ALSO PRESENT: M. Jane Ascheman

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CERTIFIED QUESTIONS

Page 20; Line 14:

Q What other records have you reviewed?

MR. PERRY: I would object to the question as attorney/client privilege, work-product privilege, and instruct him not to answer.

A No comment.

MR. HOAG: You're instructing him not to answer what other records that he reviewed?

MR. PERRY: I'm instructing -- if you're asking the name of the case or anything like that, yes, I'm instructing him not to answer.

MR. HOAG: I'm not asking him, right now at least, the name of the case.

MR. PERRY: Well, what are you asking then? You just asked him --

MR. HOAG: What other records has he reviewed.

MR. PERRY: Well, I would object -- same objection. I'm instructing him not to answer. He's already answered that, yes, he's reviewed other records. I don't know what else you want to know.

MR. HOAG: I want to know what other records he reviewed.

MR. PERRY: I would object to that as privileged, and instruct him not to answer.

MR. HOAG: Okay. We'll certify the question, but can you explain why you don't think he should be answering what other records he's reviewed in tobacco-related cases?

MR. PERRY: Well, what do you mean? Do you want to know the patient's name? What do you mean by what other records? Are they like -- were they medical records, I mean, I don't -- your question makes no sense.

MR. HOAG: I think the witness can tell me if he doesn't understand my question, but you told him not to answer it, so he must have thought you understood something about the question.

MR. PERRY: Well, what I understood your question to mean, you said what other records have you reviewed, and the only information that I can gather from that question would be who the patient is of the records he's reviewed, and I believe that is privileged information, work-product information, and I will instruct him not to answer.

If you can clarify your question, then maybe he can answer it, but as asked, I don't believe he can answer it, and I would instruct him not to answer it.

MR. HOAG: Okay. I'm not really sure I understand your objection, but let me see if I can ask some more

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questions, and we'll see what -- where that goes.

* * * * *

Page 23; Line 6:

Q And approximately how many medical records have you reviewed for Shook, Hardy and Bacon?

MR. PERRY: I would object as work-product privilege, and instruct him not to answer.

MR. HOAG: I'll certify the question.

MR. PERRY: That's fine.

* * * * *

Thereupon,

WILLIAM A. ALONSO, M.D.,

the deponent herein, being first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HOAG:

Q Could you state your name for the record, please.
A My full name is William Anthony Alonso.
Q And are you a medical doctor?
A Yes, I am.
Q Have you ever been deposed before?
A Yes, I have.
Q Approximately how many times?
A In the last 20 years, it would amount to 15 or 20 times.
Q Okay. Have you ever been deposed by telephone before?
A I think once, but I don't recall exactly.
Q The telephone deposition, how long ago was that?
A It could have been years ago.
Q My name is John Hoag, and this deposition obviously is being done over the telephone.
A Yes, indeed.
Q So if there are any problems with transmission and you don't understand something that I've said, please let me

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know. Okay?

A Yes, indeed.

Q And I'll do the same on this end if, for some reason, I don't hear what you have said.

A Fine.

Q The 15 or 20 times that you've been deposed before, what were you deposed about; in other words, were you an expert witness?

A Yes. For the most part.

Q Were you -- you were other than an expert witness at least some of those times?

A Oh, I -- I would say most of the time.

Q Most of the time you were not deposed as an expert?

A Most of the time I was deposed as an expert witness.

Q Approximately how many times have you been deposed where you were not being deposed as an expert witness?

A It would be in relation to personal injury cases, where I would guess it would be maybe three times, off the top of my head.

Q What was the nature of your testimony in those personal injury cases where you were not an expert witness?

A I was a factual witness.

Q And what facts did you testify about?

MR. PERRY: I would object to the form of the question. You can go ahead and answer, if you can.

A To the best of my recollection, because it's been many years, it would relate to the type of injury the patient had, period.

Q Were you paid for that testimony, or, I mean, were you -- yeah, were you compensated for the time you spent giving that testimony?

A I believe it would have been the compensation that's issued as part of a subpoena.

Q Were these patients that you had treated yourself?

A Yes. That I had either seen in consultation or had treated myself.

Q Have you ever been sued yourself; in other words, a named defendant in a -- yeah, named defendant in a lawsuit?

A No, I have not.

Q The remaining approximately 12 to 17 times that you were deposed, your recollection is that you were deposed as an expert witness; is that correct?

A Yes. That is correct.

Q And were you compensated for that testimony?

A Yes.

Q And how were you compensated; in other words, were you paid by the hour?

A Yes.

Q What was your hourly fee?

A Well, over the last 20 years, it's changed. Initially it might have been $150 an hour. At present it's $350 an hour.

Q And how long has your hourly fee as an expert been $350 an hour?

A It's been approximately two to three years.

Q Those cases where you testified as an expert, did you testify for the plaintiff or the defendant or both?

A I've -- both, really.

Q And how does it break down as far as number of times you testified for the plaintiff as compared to number of times you testified for the defendant?

A I probably testified in more occasions for the defendant.

Q You're not sure, but that's your best recollection, it was probably more times for the defendant?

MR. PERRY: Object to the form of the question.

A I would say that I would make it more emphatic that I have testified more times for the defendant than for the plaintiff.

Q Okay. But approximately how many times have you testified as an expert for the defendant?

A A rough guess would be in the neighborhood of 15

times.

Q Approximately how many times have you testified as an expert for the plaintiff?

A It would be three or four times -- but again, that's a rough recollection -- over the last 20 years.

Q The defendant that you testified for, is that usually a medical doctor?

A Yes, it has been, and in some instances, patients who have sustained an injury.

Q When you testify as an expert for the defendant, is it exclusively the medical -- a medical doctor who you are testifying for?

A I don't recall. I can't answer that. I would say for the most part, it probably is.

Q Okay. Now, when you were deposed, these were all obviously filed lawsuits that you were deposing -- were being deposed about; is that correct?

A To the best of my knowledge, that is correct.

Q And were they all medical malpractice lawsuits?

A No. No. As I indicated earlier, in some instances, these were accidents that had occurred; either industrial accidents, or, for instance, vehicular motor accidents.

Q Okay. Now, when they were accidents that occurred, is that when you were an expert for the plaintiff?

A Yes.

Q Okay. The other -- the times when you were an expert for the defendant, were those all medical malpractice cases?

MR. PERRY: Objection. Asked and answered.

A I can't really answer that.

Q And that's because you're not sure or --

A I'm not sure.

Q You're not sure whether every one of them was medical malpractice?

A That is correct.

Q Were the majority of those 15 times when you were an expert for the defendant medical malpractice cases?

MR. PERRY: Objection. Asked and answered.

A Affirmative.

Q Meaning yes?

A Meaning yes.

Q A majority were medical malpractice cases.

A Yes, meaning yes.

Q And when was the last time you testified as an expert -- were deposed as an expert witness?

A I would say it would have to be over a year ago.

Q And what was that case about?

A That was in support of a physician who was involved in a malpractice suit.

Q Where did that take place?

A That deposition took place in Tampa, Florida.

Q What was the name of the physician?

THE DEPONENT: Do I have to answer that?

MR. PERRY: John, the doctor's asked me if he has to answer that. I'm assuming that this was a case on file that was of public record, so --

MR. HOAG: Right.

MR. PERRY: -- unless the doctor --

THE DEPONENT: It was dismissed.

MR. PERRY: -- knows of any confidential or privileged information, then I guess I would have no objection to him answering that if he feels comfortable answering it, but I'll leave it up to the doctor.

A The case involved was dismissed, and I would prefer to protect the confidentiality of the colleague who asked me to testify on his behalf.

Q Was the record sealed?

A I don't know.

Q The lawsuit was filed in Tampa, correct?

A Yes.

Q Civil -- in state court, correct?

A I would --

Q Not federal, but state.

A It was state, yes.

Q How long ago was it filed?

A It would have been approximately three years ago.

Q What was the name of the person filing -- or the entity filing the lawsuit against the doctor?

A It was the patient, whose name I do not recall.

Q Now, this was not your patient; this was this particular physician's patient, correct?

A That is correct. I was asked to review his records as a expert witness on his behalf.

Q And you do -- right now you do know the name of that physician, correct?

A Yes, I do.

Q You are refusing to provide the name of that physician?

A I'm not refusing at all; I just want to protect his confidentiality.

Q Okay. To the extent that you were an expert witness and deposed in that case, we would have a right to know the name of the case and to make some effort to obtain copies of any transcripts of depositions if they were public record.

A I -- I don't know whether it's public record or not. The doctor's name in question, which I reluctantly reveal, is Dr. Anthony Wicks, W-i-c-k-s.

Q Who conducted the deposition; in other words, who

Q Okay. The one that was in Ohio, did that trial actually take place in Ohio?

A Yes, it did.

Q How long ago was that?

A That was at least between ten and 15 years ago.

Q What was the result of that case?

A The doctor who I testified on behalf of was found innocent of any wrongdoing.

Q What was the doctor accused of?

A He was accused of medical negligence.

Q In what regard?

A In regard to the treatment of a patient who came in to the emergency room in a town near Cleveland, Ohio.

Q What was the name of that case?

A I do not recall.

Q What was the name of the -- the physician?

A I do not recall.

Q Do you remember the name of the judge?

A No.

Q The case in Tampa that went to trial, how long ago was that?

A Approximately five years ago.

Q And what was the result of that case?

A The doctor was found innocent of any wrongdoing.

Q What was the doctor accused of in that case?

A He was accused of causing an injury during an ear operation, an injury to the patient that was being operated on.

Q And did you testify for the physician in that case?

A Yes, I did.

Q And what was the nature of your testimony?

A That the doctor had not done anything wrong.

Q And was this -- in what way was this related to your area of expertise?

A I was chairman of the ear, nose and throat department of the hospital where this patient had his surgery, and where this doctor had privileges, and was asked to review on his behalf.

Q Did any of the cases where you've testified as an expert witness settle out of court?

A To the best of any knowledge, no, but I -- I don't know for sure.

Q What was the name of the case that went to trial five years ago in Tampa -- or did it go to trial five years ago in Tampa?

A Yes, it did.

Q What was the name of that case?

A The doctor involved was Dr. J.B. Farrior, F-a-r-r-i-o-r.

Q And who is the plaintiff, if you remember?
A I do not recall the name of the patient.
Q Did any of those cases, other than this case today, any of the cases where you've been an expert witness, relate in any way to cigarette smoking?
A I don't know how to answer that question. I don't know what you're asking.
Q Did cigarette smoking have anything to do with any of the other cases where you've been an expert witness?
A To the best of my knowledge, no.
Q Did diagnosing whether or not cigarette smoking caused any disease have anything to do with any of your testimony --
MR. PERRY: Object to the form of the question.
Q -- in any other -- at any other time when you've been an expert witness?
MR. PERRY: Same objection.
A I -- I don't recall that cigarette smoking in any fashion had any bearing on any of the cases that I reviewed in the last 20 years.
Q Did any of the records reveal whether any of the patients were cigarette smokers?
MR. PERRY: Object to the form of the question.
A I really don't recall.
Q It really didn't have anything to do with any of

those cases, correct?

A To the best of my knowledge, it did not.

Q Now, you're being deposed today, and you've been listed as an expert witness by the defendants which are tobacco companies, in the Engle case. And the plaintiffs in that case, one of the plaintiffs, is Howard Engle, a medical doctor, and many, many others; it's a class action.

What, if anything, do you know about that case?

A I know very little other than what Shook, Hardy and Bacon have informed me of. But I -- I really do not know hardly anything about it, to be honest.

Q What has Shook, Hardy and Bacon informed you of related to that case?

A They supplied me medical records of a patient involved in that case, which I reviewed.

Q What patient?

A Frank Amodeo. I may be mispronouncing his last name.

Q And did they provide you with any other medical records?

A No.

Q Did you ask for any medical records?

A No. I just look at whatever they ask me to review. I don't solicit.

Q Other than Mr. Amodeo's medical records, have you

looked at any other medical records for this case?

A For this particular case, no.

Q Have you done any work on any other tobacco-related cases?

MR. PERRY: I would object to the question in that if you're just asking yes or no, has he reviewed any other records, then that's fine. If you're asking anything further than that, I would object to that and instruct him not to answer as privileged.

Q Have you reviewed any other records for any tobacco-related cases?

A Yes.

Q What other records have you reviewed?

MR. PERRY: I would object to the question as attorney/client privilege, work-product privilege, and instruct him not to answer.

A No comment.

MR. HOAG: You're instructing him not to answer what other records that he reviewed?

MR. PERRY: I'm instructing -- if you're asking the name of the case or anything like that, yes, I'm instructing him not to answer.

MR. HOAG: I'm not asking him, right now at least, the name of the case.

MR. PERRY: Well, what are you asking then? You

just asked him --

MR. HOAG: What other records has he reviewed.

MR. PERRY: Well, I would object -- same objection. I'm instructing him not to answer. He's already answered that, yes, he's reviewed other records. I don't know what else you want to know.

MR. HOAG: I want to know what other records he reviewed.

MR. PERRY: I would object to that as privileged, and instruct him not to answer.

MR. HOAG: Okay. We'll certify the question, but can you explain why you don't think he should be answering what other records he's reviewed in tobacco-related cases?

MR. PERRY: Well, what do you mean? Do you want to know the patient's name? What do you mean by what other records? Are they like -- were they medical records, I mean, I don't -- your question makes no sense.

MR. HOAG: I think the witness can tell me if he doesn't understand my question, but you told him not to answer it, so he must have thought you understood something about the question.

MR. PERRY: Well, what I understood your question to mean, you said what other records have you reviewed,

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and the only information that I can gather from that question would be who the patient is of the records he's reviewed, and I believe that is privileged information, work-product information, and I will instruct him not to answer.

If you can clarify your question, then maybe he can answer it, but as asked, I don't believe he can answer it, and I would instruct him not to answer it.

MR. HOAG: Okay. I'm not really sure I understand your objection, but let me see if I can ask some more questions, and we'll see what -- where that goes.

Q Have you reviewed any other medical records in any other tobacco-related case?

MR. PERRY: I would object as asked and answered.

Q Have you reviewed any other medical records in any other tobacco-related cases?

MR. PERRY: Same objection. Doctor, you can answer yes or no.

A Yes.

Q And what is your understanding of the term medical records?

A These can be copies of the treatment of a specific patient by either a physician, by a hospital, or by some other health care agency or institution.

Q And those other medical records that you've

reviewed, were they supplied to you by Shook, Hardy and Bacon?

A Yes.

Q At your request?

A Not at my request. I do not solicit cases.

Q And approximately how many medical records have you reviewed for Shook, Hardy and Bacon?

MR. PERRY: I would object as work-product privilege, and instruct him not to answer.

MR. HOAG: I'll certify the question.

MR. PERRY: That's fine.

MR. HOAG: How do you -- what do you base asking how many as being privileged? How does that get into a privilege when I ask how many?

MR. PERRY: Well, I think it gets into privileged information as to how many cases he's reviewed. You've asked him if he's reviewed others; he said yes. And I don't think he -- that he's obligated to provide you any more information, so I'm instructing him not to answer your --

MR. HOAG: I guess I was just trying to save some time, rather than have to go back to a judge on issues like how many records, because there's really nothing privileged about how many records. I mean, you may have some arguments that you could make as to the names

of specific patients, but I haven't asked that.

MR. PERRY: Well, I understand that, but I'm still going to instruct him not to answer. And if we have to come back and if he wants to answer that one question if the judge tells him to, then we'll do it.

MR. HOAG: Well, that one question can lead to other questions.

MR. PERRY: Well, if it does, then those other questions can come out at the time we come back and he answers that question.

MR. HOAG: For the record, I feel that you're being obstructive now and just making it difficult for us to do our job.

MR. PERRY: Well, for the record I feel that you're doing the same thing, so why don't we move on.

MR. HOAG: Well, it's hard to move on, because you're objecting and not letting him answer questions.

MR. PERRY: Well, I'm objecting to questions which I believe are privileged, which is my right to do.

MR. HOAG: Well, you haven't given me a single basis other than saying it's privileged. Why is it privileged to say how many medical records have you looked at, other than your blanket, conclusive statement that it's privileged?

MR. PERRY: I'm not --

MR. HOAG: What's privileged about that?

MR. PERRY: I'm not going to spend this whole deposition arguing with you, John. I've made my objection, you've certified the question. Let's move on.

MR. HOAG: Right. You can't think of a basis for claiming a privilege, but you're going to do it anyway.

MR. PERRY: No. John, I would object to your characterization, and ask you to move on.

Q Other than Shook, Hardy and Bacon, have you been contacted by any other law firm that represents tobacco companies?

A No; I have not.

Q When were you first contacted by Shook, Hardy and Bacon?

A I think it would have been approximately March of 1997.

Q March of 1997?

A Yes. Approximately. It could have been a month later, I -- you know, I'm just guessing.

Q And who contacted you?

A I was contacted by a -- an attorney in Tampa, who I know socially.

Q Who is that?

A Mr. Larry Stagg.

Q S-t-a-g-g?

A Yes.

Q How do you know him socially?

A I play golf with him.

Q Does he work for Shook, Hardy and Bacon?

A He's in a separate law firm in Tampa, Florida.

Q But did he contact you about being a witness for Shook, Hardy and Bacon?

A No. He just asked me if I would be able to review some records, and I didn't know who the records were from, and he explained the context.

Q Does Mr. Stagg also represent tobacco companies, any tobacco company?

A I don't know who he represents, to be honest with you. I don't know anything about his professional life as an attorney.

Q How long have you socialized with him?

A I've known -- he's been my good friend and person I truly like for close to 20 years.

Q Okay. So he asked you -- was it sometime in March of '97 that he asked you --

A That's my best guess.

Q Okay. So he asked you if you would be able to review some records.

A Yes.

Q And he told you the records were -- did he tell you what they were about, the records?

A I think he might have said something to the effect, related to tobacco industry, but I -- I don't know, and I -- I may be, you know, imagining words that are not there.

Q And what did you say when he asked you if you would be able to review some records?

A I said that, you know, to get in touch with me at my office, because this was on the golf course.

Q And when you said to get in touch with you, did you mean him or someone else?

A Well, I think he was really -- I believe, to the best of my knowledge, that he was really a go-between, and a subordinate, a younger attorney in his firm, then subsequently came to my office.

Q Who was that younger attorney?

A Mr. Pedro Bajo, capital B-a-j-o.

Q What's the name of his firm?

A I think he's part of Mr. Stagg's firm.

Q And what is the name of that firm?

THE DEPONENT: What's the name --

MR. PERRY: If you know.

A I think it's Akerman something.

Q Okay. You're not sure, but you think it's Akerman

something?

A Yes. I think there are three names, and Akerman is the first name for sure.

Q The second name start with an S? Akerman, Senterfitt and Eidson; is that --

A That sounds correct.

Q And that would be spelled A-k-e-r-m-a-n, S-e-n-t-e-r-f-i-t-t, and E-i-d-s-o-n; is that right, or do you know?

A I think you're right.

Q Okay. So an associate or a colleague of Mr. Stagg's came to see you; his name is B-a-j-o?

A Yes, sir.

Q He came to see you, and what did he say, if anything?

A He came with an attorney from Shook, Hardy and Bacon.

Q And who was that attorney?

A Mr. Curtis Perry.

Q And other than Mr. Perry and Mr. Bajo, were there any other people there?

A No; not to my recollection.

Q Okay. And when they came to see you, what, if anything, did they say to you?

A They explained, you know, what the nature of their

request was, for me to review some records pertaining to the tobacco industry; medical records of patients, of course.

Q So they explained the nature of the request for you to review some medical records.

A Of patients, yes.

Q What did they explain about that?

A Just to see what my impression was as to the relationship between the patients's medical history and their possible use of tobacco.

Q And what, if anything, did you say when they explained that to you?

A I said I would review the records.

Q Had you ever done anything like that before you were asked to do it in March of 1997?

A I -- I've never worked for the tobacco industry.

Q Prior to that time, had you ever reviewed patients's medical histories to look at -- I'm sorry. Withdraw that question.

Prior to that time, and I'm talking March of 1997, had you ever reviewed patients's medical records and the possible use of tobacco?

MR. PERRY: I would object to the form of the question. Are you talking about as an expert witness, John?

MR. HOAG: Ever.

A Not to the best of my knowledge.

Q It wasn't -- it wasn't an area of interest to you; is that correct?

A The issue never came up.

Q When you say the issue never came up, do you mean it never came up at any time during your medical practice?

A Prior to the request that was made on or about March of 1997, I had never been asked.

Q And it also -- it wasn't anything that you paid attention to as a medical practitioner, correct?

A To the extent of reviewing records in relation to the use of tobacco; is that what you're saying?

Q Yes.

A I'm not sure I understand your question.

Q You just repeated it accurately.

A I don't know how to answer it, so please rephrase it.

Q Did you, prior to the time you were contacted by representatives of the tobacco industry, prior to that time, did you ever have any interest in looking at the possible use of tobacco or cigarette products in a patient's medical history.

A As an expert witness?

Q As a medical doctor.

A I take the social history of every patient I see

in my office, and instruct my students to do the same, and this -- this includes any form of use of substance, whether it's marijuana, whether it's alcohol, whether it's recreational drugs such as cocaine, or whether it's tobacco use. All of these are pertinent aspects of a complete medical history as taken by any physician.

Q So you have a standard form that includes tobacco use?

A We -- we put it in as part of the history that's taken initially. This is part of what we put together in the patient's medical record, especially when they come in as a new patient.

Q Okay. And in that history that's taken, is there a standard question related to tobacco use or a standard series of questions?

A There -- I don't know that there's a series, but there certainly is at least one question.

Q What is that one question?

A "Do you smoke" or "Do you use tobacco products", to the best of my recollection. I don't have the form with me here that I use in my office or in the hospital.

Q You've used it several times -- many times, correct?

A Yes. It's -- it's something that I've done since the day I started seeing patients for the first time in

medical school. It's part of the history gathering, which, as I mentioned, includes many other things.

Q Okay. So you ask the patient, each patient, "Do you smoke," correct?

MR. PERRY: Objection. Asked and answered several times.

Q Is that correct?

A Yes.

Q And if they say yes, do you ask them anything else about smoking?

A We try to get an idea for how long and to what extent, and just what do they smoke; do they smoke marijuana or pot, just what they mean by that.

Q And do you put -- write that all down in the medical record?

A Yes, I do. These are confidential medical records, so as it pertains to the good care of the patient, this is inscribed in their confidential medical record.

Q So you, in those -- in each of these medical records, at least where you ask the question if a person smokes, you find out what they smoke and how much they smoke; is that correct?

MR. PERRY: Objection. Asked and answered.

A Yes.

Q And how long they've smoked?

A Yes.

Q Is that correct?

A Yes.

Q And do you break that -- if they're a cigarette smoker, do you break that down by how many packs they smoke a day?

A I try to get them to give me a range, to give me some, you know, rough idea.

Q What range do you look for?

A Whether they smoke one pack, or less than a pack, or more than a pack, this type of thing. We try to get, you know, as close to an estimate as possible.

Q Have you ever done an analysis of any of those medical records to compare smoking habits to a disease?

A No, I have not.

Q Why?

A I have no reason to.

Q Would any medical doctor have a reason to do that?

MR. PERRY: Objection to the form of the question.

MR. HOAG: You can answer.

A If you're doing a retrospective or prospective epidemiological study at an institution, and you're garnering this information for purposes of either presentation at a medical conference or possible publication. This is the kind of thing that is done at

medical centers, namely medical schools and teaching hospitals.

Q You do any work for a medical school?

A Yes, I do.

Q How long have you been doing that?

A I've been involved with my present position on the clinical staff of the University of South Florida since 1975.

Q I want to go back to that, but let me ask you a few more questions about what the attorneys showed you or asked you to look at.

Other than medical records, was anything else provided to you by the attorney from Shook, Hardy and Bacon or from the Akerman law firm?

MR. PERRY: Object to the form of the question. What time frame are you talking about, John?

MR. HOAG: March of 1997 to the present.

A I've looked at depositions, as well as medical records.

Q What depositions have you reviewed?

MR. PERRY: Object to the form of the question. That's privileged and I'll instruct him not to answer.

MR. HOAG: Oh, boy. The depositions that he's reviewed is privileged?

MR. PERRY: Yes. Unless you're talking about

the Engle case.

Q Are any of your opinions that you have based in part or in whole on any of the material provided to you by the attorney for Shook, Hardy and Bacon or for the Akerman firm?

MR. PERRY: I would object to the form of the question. Are you talking about things we provided to him in the Engle case or anything we've ever provided to him?

MR. HOAG: Anything. Because obviously there are things that he could have read in other cases that would be at least a partial basis for opinions in this case, and that's what I'm asking him.

A It hasn't influenced my opinion one way or the other, none of the material.

Q None of the material --

A Has influenced me in the least bit.

Q None of the material you reviewed in any case.

A In respect to any medical records or depositions that I've received from Shook, Hardy and Bacon, it has had no bearing on my opinions.

Q Approximately how many hours have you spent so far working on these cases?

A Are you talking about the Amodeo, Frank Amodeo case with respect to Engle?

Q No. I'm talking about all the time you've spent working on tobacco-related cases for Shook, Hardy and Bacon.

A I would say -- in hours, you say?

Q Yes. In hours.

A I would think approximately 25 hours. It might be a few more than that, you know, it's -- that's just a -- an off-the-cuff number. About 25 hours; between 25 and 30, to give a range.

Q Okay. Of those 25 to 30 hours, how many of them were on the Engle case?

A I would say approximately six.

Q Is that not counting this deposition?

A Not counting this deposition.

Q Do you plan to do any additional work on the Engle case prior to testifying at trial, if, in fact, you testify at trial?

A That's up to Shook, Hardy and Bacon. I react to their requests; I don't request anything.

Q Other than depositions and medical records, have you reviewed anything else as an expert witness for Shook, Hardy and Bacon?

A To the best of my knowledge, no.

Q Have you been provided with any peer review journals or textbooks or anything of that sort?

A Absolutely not.

Q Have you done any additional research of your own since being contacted in March of 1997 by Shook, Hardy and Bacon?

A Not -- not as -- as a specific, what do you call it, request or reaction to Shook, Hardy and Bacon. In other words, I continuously continue my continuing medical education, and I monthly receive journals in my field, so I'm continuously trying to stay current or better than current.

Q What journals do you subscribe to?

A I receive principally within my specialty field of ear, nose and throat, head and neck surgery, I receive the Head and Neck Surgery Journal; I receive the Annals of Otology, Rhinology and Laryngology; I receive the Laryngoscope; I receive the ENT Journal; and I read, from time to time, the Archives of Otolaryngology, which is an AMA publication; as well as the Yearbook of Ear, Nose and Throat; as well as the Otolaryngologic Clinics of North America. And then I read some journals in Spanish that are sent to me from Columbia and Mexico.

Q Have you read any epidemiological studies concerning cancer and cigarette smoking?

A I have not looked at any publications from public health departments or epidemiologists. I don't receive any of their journals, and I don't recall that I have read any

of their articles.

Q Have you ever read any epidemiological studies related to cigarette smoking and disease?

A I may well have, and I don't recall.

Q Do you have an opinion as to whether or not cigarette smoking causes any disease?

MR. PERRY: Object to the form of the question. That was outside the scope of his expertise.

MR. HOAG: I'm asking him a question, for goodness sake.

MR. PERRY: I know. Can I finish my objection, please?

MR. HOAG: Well, you're wasting time, but go ahead.

MR. PERRY: No, I'm not. You're wasting time.

MR. HOAG: By asking him that question?

MR. PERRY: Yes. Let me finish my objection, and then you can see what my point is.

My point is: You're asking him any disease. He's offered as an expert in otolaryngology, ENT, so by asking him a question of any disease, I think that's overbroad, and I object to the form of the question.

MR. HOAG: Okay. Now you can read the question back, please, Ms. Court Reporter, and then I'd like him to answer the question.

(Whereupon the court reporter read back).

MR. PERRY: Same objection. You can answer.

A I -- I will only answer that within the framework of my area of expertise, which is ear, nose and throat, and head and neck surgery. I don't know what the word "cause" is in your question. I'm not sure what you mean by "cause". If you're talking about contributing factors, that's another question. Would you please clarify that.

Q What is your definition of "cause"?

A Well, what -- what we learned in physics, cause and effect. That means that there's a specific cause with a resultant effect. Newton, I think, first talked about this.

Q You mean like gravity?

A Yeah. These are things that, based on mathematical formula, you can come to an almost precise and exact result, an exact answer.

Q Does cigarette smoking cause any disease?

MR. PERRY: Object to the form of the question.

A Again, I have problems with the word "cause". Cause has a finality to it. If you're talking about cause as more generic, meaning a contributing factor, a risk factor, that's a different story.

Q Well, you can use the term any way you want to use it. How do you use the term "cause"?

MR. PERRY: I object to the form of the question.

beings. In other words, he had to confirm to three conditions, and this, in the -- in the scientific method was the way he found that the tubercle bacillus, which had otherwise been hard to identify, was the cause of the disease tuberculosis. And this is used as a pattern for scientific inquiry and discovery.

Q Okay. Let me ask you, aside from -- I already asked you the question about does it have to be the cause 100 percent of the time for it to be a cause; you answered that one.

Does it have to be the only thing that causes disease to be a cause?

A I don't think I can answer your question. I'm not sure I understand it.

Q Well, like for example, a virus, does a virus have to be the only thing that causes pneumonia for the virus to be a cause of pneumonia?

MR. PERRY: Object to the form of the question.

A I don't -- I'm not sure I follow. It's well-known that you can have viral pneumonia. You can isolate the virus from the sputum of somebody with pneumonia, or at autopsy find the virus in the lung; therefore, as, you know, I might say the -- the proof is in, you know, what you find under the microscope. In other words, you can certainly isolate the infectious virus and identify it with the place

in the lung where the pneumonia took place.

Q So it's not necessary for -- for a virus to always be the cause of pneumonia for virus to cause pneumonia, right?

A I don't think I follow that.

Q It is necessary for a virus to always be the cause of pneumonia for it to be a cause?

A Pneumonia has a myriad of causes.

Q That's what I wanted to know.

A The most common cause is a bacterium.

Q Right. So many different things cause pneumonia, right?

A Yes. And they follow different clinical patterns.

Q Right. So now, getting to the issue of causation as to cigarette smoking, on a -- you've seen the Surgeon General's warning on cigarette packages, right?

A Yes.

Q And one of those warnings says, "Warning: Cigarette smoking causes lung cancer, heart disease and emphysema." Do you agree with that warning? Do you think that warning is accurate?

MR. PERRY: I would object to the form of the question, and also object that it's outside his area of expertise.

MR. HOAG: You can answer.

A I can't answer; only in respect to the area that I deal with. I will say that a lot of these warnings are based on public health or epidemiological data, and are primarily intended to indicate a risk factor.

Q Are you familiar with risk factors?

MR. PERRY: Object to the form of the question.

Risk factors of what?

Q The risk factors for disease.

A Well, what disease?

Q What disease -- are you familiar with risk factors for any disease?

A I'm familiar with risk factors that contribute to diseases in my area of expertise.

Q And what diseases are those?

A Well, I'd have to, you know, write a textbook to tell you all the diseases that can affect the head and neck area that I treat. We'd be here till doomsday.

Q Have you seen your disclosure statement --

A Yes.

Q -- in this case? Did you write it?

A I instructed in the content, but I did not type it. And I -- and I proofread it after it was prepared.

Q Well, the disclosure statement -- you agree with everything in it, correct?

A It -- it's -- it's what I told them to include.

Q Now, you're going to testify regarding the diagnosis or treatment of cancers of the head and neck, correct?

A This is the area that I'm involved in as regards my specialty.

Q Now, one of the things it says here in the second page of your disclosure statement, second sentence, first paragraph -- do you have that in front of you?

A Yes.

Q It says, "Some cancers of the head and neck have been reported to be statistically associated with smoking." Is that what -- you wrote that, right?

A Yes.

Q Okay. What cancers of the head and neck have been reported to be statistically associated with smoking?

A These are squamous cell carcinomas, for the most part, and different histologic variations on squamous cell carcinoma.

Q Other than squamous cell carcinoma, anything else?

A That -- that would be by far the most significant aspect; that particular histologic type is by far the most commonly associated with smoking.

Q In what way is that associated with smoking?

A It -- it's been indicated that people that have smoked tobacco products, whether it's cigars, pipes,

marijuana or cigarettes, there seems to be a statistical correlation with the development, the onset of a squamous cell carcinoma.

Q What is that statistical correlation?

A I don't know what the correlation factor is. I do not know.

Q Okay.

A I'm not a statistician.

Q Well, something with a factor of ten, what would that mean?

MR. PERRY: Object to the form of the question.

A That's a statistical question. I said I was not a statistician.

Q So you don't know what a risk factor of ten means, correct?

MR. PERRY: Object to the form of the question.

It's not what he said.

Q Is that correct?

A I'm not sure what you're trying to ask me. I don't understand.

Q Do you know what a risk factor of ten is, what that means?

A Yes, I do.

Q What does it mean?

A In rough terms, it means a high risk.

Q Well, what -- in more specific terms, what does a ten mean? What does that represent?

MR. PERRY: Object to the form of the question.

A I cannot answer your question. I do not know what you're talking about.

Q Well, how do you know in rough terms what it means then?

A This -- this is the kind of thing that you might hear at a medical conference. I have not dealt in the public health study of any disease, and in particular, cancers of the head and neck, and I have not dealt in, you know, statistical analysis of data either. I don't pretend to be an expert in this area, and that's the end of it.

Q Okay. So you -- fair statement that you have no idea what the risk factor is for cigarette smoking and cancers of the head and neck that are associated with cigarette smoking; is that correct?

MR. PERRY: Object to the form of the question. That misstates his testimony.

A I didn't say that. I said that in terms of getting into statistical analysis and study, I defer that to a person who is a statistician or who works day in and day out with statistics. I do not.

Q So all you know is that cigarette smoking is a risk factor for some head and neck cancers, correct?

A That is exactly what's in my disclosure, and that's exactly what I'm saying.

Q But you don't know how big a risk factor it is.

A I won't quantitate it because I'm not a statistician.

Q And you don't have that knowledge anyway, correct?

MR. PERRY: Object to the form of the question.

A I am not a statistician. I do not have the knowledge of a statistician; that is correct.

Q Do you need the knowledge of a statistician, as a medical doctor, to know what the risk factor for cigarette smoking is for diseases of the head and neck?

MR. PERRY: Object to the form of the question.

A Well, I already said in verbal terms that I felt that smoking was a significant risk factor in squamous cell carcinoma of the head and neck. I'm just reiterating what I've already said.

Q When you say significant, what do you mean?

A I'm not a statistician, so that adjective stays as -- as stated. I'm not going to quantify it because I'm not a statistician. I've said that, I think, at least a dozen times.

Q Do you ever do a diagnosis of a cause of a person's disease?

MR. PERRY: Object to the form of the question.

A Could you restate that?

Q Have you ever done an assessment of what causes a particular patient's disease?

A I -- you mean in terms of biopsying a cancer and identifying it as the cause for the patient's symptoms? This I do all the time, biopsying and diagnosing that the person has a cancer of the head and neck. Is that answering your question?

Q So you diagnose that they have a cancer, correct?

A Yes. This has to be done because you cannot treat a cancer, a suspected cancer, without histologic proof.

Q Okay. Now, that's not the same thing as assessing what caused the cancer in the first place, right?

A Well, if I knew what caused the cancer, I'd be in Stockholm receiving the Nobel Prize, or I would have received it already.

Q In order to state a medical opinion, do you have to know something with absolute certainty?

MR. PERRY: Object to the form of the question.

A You -- you can suspect that there is a problem, but the proof is in the pudding, and before treatment is engaged, a biopsy and a thorough evaluation of that biopsy has to be entertained by a pathologist.

Q Okay. Now, I want to separate out the difference between diagnosing that a person has cancer as compared to

assessing what caused the cancer.

Now, you've said -- you have said, I guess your words are that you'd be ready for a Nobel Prize if you were capable of assessing the cause of any head and neck cancer; is that correct?

A If I knew the cause of cancer, I will have won the Nobel Prize, and then some.

Q So is it your opinion that the cause of lung cancer -- that none of the causes of lung cancer have been established? Is that your opinion?

MR. PERRY: I would object to the form of the question. Lung cancer is outside his area of expertise.

A I -- I have no comment on that. I do not treat or diagnose lung cancer.

Q Have you read any of the epidemiological studies on lung cancer and cigarette smoking?

A If I've seen an epidemiological study, I -- I, you know, don't recall specifically where. In other words, it's possible, but I don't recall that I have looked at any specific study. I don't receive any of the public health or epidemiological trade journals.

Q In your opinion, is it possible to assess whether or not anything is a cause of any head or neck cancer?

MR. PERRY: Object to the form of the question.

A I don't think I understand your question.

Q Are there any circumstances under which you would be able to express an opinion as to whether or not cigarette smoking caused any head or neck cancer?

A The word caused is, again, the problem, which we've addressed before, so I won't go into that. I consider, as I said in my declaration, that it is a significant risk factor in squamous cell cancer of the head and neck, including the larynx.

Q In your opinion, is it more likely than not that at least one person has died prematurely as a result of smoking cigarettes?

MR. PERRY: Object to the form of the question.

A Are you talking in reference to my area of expertise as regards diseases of the head and neck?

Q Yes.

A I would say yes, it's certainly possible.

Q Is it more likely than not?

A Yes. I would say it's more likely than not.

Q And why would you say that?

A Well, because I consider that smoking, as I indicated in my declaration, is a significant risk factor. It's compatible with what I just said.

Q So it's more likely than not that at least some individuals, if they would not have smoked cigarettes, they

would not have died prematurely from head or neck cancer?

MR. PERRY: Object to the form of the question.

Q Correct?

A Well, I think, again, you want to clarify what you mean prematurely. I don't understand that particular qualification.

Q What -- do you have a definition of the -- for the term "premature death"?

A No. No. You're the one who made the question. You tell me what you mean by premature death.

Q I'm asking you if you have a definition for the word "premature death".

A Well, cancer, as a disease entity, and in respect to the area of my expertise in the head and neck, is primarily a disease of the seventh decade of life, and thereafter. So anybody who might die earlier than the seventh decade of life would be basically dying prematurely.

Q Now, are people who smoke cigarettes more likely to die of head and neck cancers prior to the seventh decade of life than people who do not smoke cigarettes?

A I don't know. I -- I consider that cigarette smoking is a risk factor, among other risk factors, and it depends on how early the cancer that the person has is identified and duly treated.

Q What are the other risk factors for head and neck

cancers?

A Well --

Q For head and neck cancers that in your opinion are associated with cigarette smoking.

A Well, besides cigarette smoking?

Q Yeah. Other than -- other than cigarette smoking, what are the other risk factors?

A Well, I enumerated some other tobacco products, such as chewing tobacco, pipe smoking, cigar smoking, marijuana smoking, chewing bejel nuts, being exposed to radiation, I -- you know, there -- asbestos. There are a myriad of industrial problems that have been associated with cancer.

Q Other than ones you've named, what are the other myriad of risk factors?

A Well, I'd have to probably look into my ear, nose and throat texts, and add, you know, other factors. Alcohol is another significant factor. Alcohol abuse is associated, again, with mouth and throat cancer.

Q Is cigarette smoking also associated, in your opinion, with mouth and throat cancer?

A Yes. I said it was, in my opinion, a significant risk factor.

Q What is the -- aside from alcohol and cigarette smoking and other forms of smoking different products, what

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are the other risk factors for mouth and throat cancer?

MR. PERRY: Object. Asked and answered.

A I think I already said.

Q You've already answered that?

A Yes.

Q Okay. Now, and is that a disease that you'd expect to occur in the '70s, seventh decade of life?

A Yes. That's generally the highest incidence of cancer in the head and neck region.

Q What is the incidence, the percent of people who contract those diseases, what percentage of them contract in the seventh decade?

A What percent of the U.S. population in the seventh decade has a cancer of the head and neck?

Q No. What percentage of the people who contract either mouth or throat cancer contract that disease in the seventh decade as opposed to any other decade of life?

A Well, I'd say it's over 50 percent.

Q You don't know, but you're just -- are you guessing now?

A It's a learned guess.

Q What's it based on?

A My experience and knowledge.

Q It's based on your observation of patients?

A My observation of patients; my treatment of

patients; my supervision of the care of patients; my exhaustive reading; my attendance at many, many, many scientific congresses, assemblies.

Q Okay. Have you ever published any articles related to the relationship between cigarette smoking and head and neck cancers?

A I have never done a epidemiological or public health article with respect to the relationship between cigarette smoking and the development of head and neck cancer.

Q Have you ever done one with relationship to any of the other risk factors?

A No. I've never done any public health study with respect to head and neck cancer.

Q Have you ever published in peer reviewed journals?

A No.

Q Never?

A I'm not sure what you mean by peer reviewed journals.

Q What's your understanding of the term "peer reviewed journal"?

A I have published in established scientific publications in my field, but I don't recall any of these journals being called "peer review journal".

Q What's your understanding of the term "peer review

journal"?

A I -- I consider peer review to involve reviewing the treatment of colleagues such as we do in utilization review in the hospital. But I'm not sure what you mean by peer review. If you're talking about continuing medical education, then I understand it.

Q Assuming that peer reviewed journal means that if someone submits for publication a piece of research, that piece of research is then reviewed by colleagues of equal or greater caliber than the person submitting it prior to publication. Do you know whether or not you've ever published any articles in peer reviewed journals?

A I -- I understand your question, finally. We had a semantic problem.

You're asking me if I have reviewed articles submitted to journals prior to publication for me to then give my support or -- or negative review of that particular article, whether it should be published or not; is that what you're talking about?

Q No. It's a good question, though, but that's not what I was asking.

What I was asking was: Have you ever submitted anything for publication that was reviewed by other people under the circumstances we've just described?

A Oh, yes. Every article that I've had published is

reviewed by the editorial board of the journal. And I have done the same. I have been a reviewer for the editorial board of the Laryngoscope and the editorial board of the Annals of Otology, Rhinology and Laryngology.

Q And what is the last year that you published an article in a peer reviewed journal?

A 1996 I published a chapter for a textbook.

Q That's not -- I'm not asking about textbooks right now; I'm asking about peer reviewed journal articles.

A What you mean by that are scientific journals in my field; is that what you're talking about?

Q Yes.

A I -- it's not in this listing, but there was a -- an article that was published after a Pan American meeting last year, and that would have probably come out sometime this year in the Mexican Journal of Otolaryngology.

In the list that you have -- yeah, this is the type of thing, see, that would have been published. Yeah. It would have been 1981, as far as an original article is concerned.

Q That's -- that's the number 36 on your resume that's titled --

A Yes.

Q -- Heterotrophic --

A Yes.

Q Why has it been so long since you've published in a peer reviewed journal?

A I don't have the time.

Q Have you reviewed any other depositions -- no, I'm sorry, withdraw that question.

Have you reviewed any depositions in the Engle case?

A I reviewed one deposition in the Engle case on a patient, Frank Amodeo.

Q Okay. So you reviewed his deposition and also his medical records, correct?

A That is the only case that I reviewed for Engle.

Q Okay. Do you have any opinion based on reading his medical records and his deposition?

A I haven't completed my review of the information that is available or will be available on this patient. In essence, that's not finalized at this point.

Q So at this point, you don't have an opinion.

A I do not.

Q Have you prepared any written reports for the attorneys for the Engle case?

A No; I have not.

Q Do you plan to prepare any written reports?

A I haven't been asked to.

MR. HOAG: Okay. Now, for the record, we move to

strike any opinion that he may have in the future about Amodeo, his medical records or his deposition.

MR. PERRY: And we would object to that.

MR. HOAG: That's an issue, obviously, we'll have to address if it comes up, but we'll -- we'll just make our motion for the record now.

MR. PERRY: John, is this a good place for a break? We've been going about an hour and a half.

MR. HOAG: Sure.

MR. PERRY: All right. Let's take about five minutes.

(Whereupon a recess was taken).

Q Okay. Doctor, during the break, did you discuss this case?

A No; I did not.

Q Did your attorneys discuss the case with you at all?

A No. Not at all.

Q Okay. The risk factors you named, I want to ask you a question related to that.

You named various form -- the risk factors for mouth and throat cancer specifically, you named various forms of tobacco use: Chewing tobacco; pipe smoking; cigar smoking; marijuana smoking, which is not tobacco, of course; you named radiation; asbestos; and some gel?

A Well, that's in -- in the Far East, that's bejel nut, b-e-j-e-l.

Q That's in the Far East?

A Yes. That's in India.

Q So if you weren't in India, that wouldn't be likely to be a risk factor for you; is that right?

A If you were in India, yes.

Q But if you were not, it wouldn't be likely to be a risk factor.

A Unless, you know, people have strange customs, you know; they might bring those things back and chew them here.

Q Okay. Now, hypothetically --

A Another one that I should have included in tobacco, if you don't mind, would be snuff; less common today because snuff is not as popular, but this is certainly another form of risk factor, as well as alcohol, which I should have mentioned with more emphasis in my listing.

Q Do you know what the risk factor is for alcohol?

A I don't know specifically what it is, but I would consider it a significant risk factor, you know, along with, as I said, smoking. You can call it a ten, if you wish; that -- that would be fine with me.

Q No, I don't want to call it anything. I want to know what you know, what you call it.

A Well, I'd call it a ten. I'd say it's a ten.

Q And what does that mean to you, that word -- that ten?

A Well, ten, you know, if it's a scale of ten, ten being the most significant or high degree, ten would be high, a high risk factor.

Q Okay. Now I'll tell you what I mean by ten. My definition of a ten as a risk factor means that a person who, for example, smokes cigarettes is ten times more likely to contract the disease than somebody who doesn't smoke cigarettes; that's a ten.

A That's fair enough.

Q Okay. So when you call alcohol a ten, do you have any idea whether it's a ten by the definition I just gave?

A Yes. I would call it a ten, depending on the amount of alcohol consumption and the type.

Q You mean if you smoke -- if you drank a lot of alcohol, it would be ten, and if you drink one or two drinks, it would be a lot less; is that what you mean?

A Yeah. Depending on the type of alcohol, and the volume consumed per diem would have to do with whether it's a two, a three, a four, a five, a six, an eight, a nine or a ten.

Q Okay. What about cigarette smoking?

A I think the same thing would apply as a risk factor.

Q You'd use the same kind of numbers?

A Yes. And there again, I can't specifically quantitate in terms of number of cigarettes. There are factors such as heredity, genetic predisposition, underlying diseases that make a person more susceptible, whether it's to alcohol or tobacco or both.

Q What are the genetic predispositions that make a person more susceptible to tobacco or to cigarette smoking?

MR. PERRY: Object to the form of the question.

A There can be a family history, which is part of the information we gather, as I mentioned earlier in the deposition, and there may be a grandfather, a father, an uncle, etcetera, who may have also developed a cancer in the head and neck region. There can be a suggestion that there is a predisposition in the family, a susceptibility, if you will, but nobody has isolated a specific gene, to my knowledge, that you can correlate with predisposition to any cancer in the head and neck.

Q Okay. Now, hypothetically, assuming an individual who has smoked cigarettes for 20 years, smoked two packs a day for 20 years, contracts throat cancer at the age of 40 and has none of the other risk factors for throat cancer, would you be able to express an opinion as to whether or not cigarette smoking was a cause of that individual's throat cancer?

MR. PERRY: Object to the form of the question.

A It, again, would be a matter of defining the word cause, which we've already been into many times.

I would say that smoking may well be a high risk factor in that rare individual who, at the age of 40, contracts a significant cancer of the head and neck, and it would have to be an area presumably in the mouth or throat.

Q All right. If you eliminated all the other risk factors other than the two packs a day of smoking for 20 years, would it be more likely than not that that individual's throat cancer was as a result of the cigarette smoking?

MR. PERRY: Object to the form of the question.

A Are you using the word "as a result of", that phrase, in exchange for the word "cause"?

Q I'm using it exactly like I used it. Is it more likely than not that the cigarette smoking resulted in the throat cancer for an individual who had no other risk factors and contracted throat cancer at the age of 40, and had smoked for 20 years, two packs a day?

MR. PERRY: Same objection.

A I can't answer your question.

Q You don't know? Is your answer you don't know the answer?

A If I did, I'd have the Nobel Prize --

Q Okay. So you're saying --

A -- in medicine.

Q Are there any circumstances under which you would be able to give an opinion as to whether or not it was more likely than not that an individual cancer of the mouth or throat was as a result of cigarette smoking?

A I -- I have no problem when you qualify it as more likely. I think that we consider that it is a high risk factor, and it more likely can contribute to a problem, yes. It can more likely contribute to a problem such as the cancer that you have stated.

Q All right. So if someone asked you -- if you looked at someone's medical records, and that person was 40 years old, had throat cancer, and had smoked cigarettes for 20 years, two packs a day, and had none of the other known risk factors, would you be able to express an opinion concerning whether or not cigarette smoking had resulted in that person's throat cancer?

MR. PERRY: Object. Asked and answered. You can answer again if you can, Doctor.

A I would consider that cigarette smoking would be a high risk factor in this individual. There may be other known related risk factor situations such as we mentioned before, genetic predisposition, the person's immune status, as affected either by heredity or by age.

Q But my hypothetical assumes that none of the other risk factors were present other than cigarette smoking.

A My answer's the same.

Q I believe your answer was that you have to consider the other risk factors.

MR. PERRY: Object. Is there -- misstates his testimony, and I don't think that's a question, but --

MR. HOAG: Can you read back his last answer, please. Not "My answer", but his answer before that, please.

(Whereupon the court reporter read back).

MR. HOAG: Okay. You can stop there.

Q Now, I wasn't asking whether a cancer was a high risk factor -- I mean whether cigarette smoking was a high risk factor; my hypothetical was the assumption that there were no other known risk factors present for this individual.

If there are no other known risk factors present for this individual, and the only risk factor is that the person smokes -- has smoked for 20 years, two packs a day, is it more likely than not that that person's throat cancer resulted from cigarette smoking?

MR. PERRY: Object. Asked and answered.

A My -- my answer would stay the same. I think that I cannot state the cause or result -- resulting in cancer

because I don't know what causes cancer.

Q Our Notice of Deposition includes an attachment where you were asked to bring some documents with you today. Did you bring any documents with you today?

A I brought the documents as requested, to the best of my knowledge.

Q What documents did you bring with you today?

A I have the -- I'm sorry. Do you want me to go ahead?

Q Yeah. What requested documents did you bring with you today, is what I'm asking.

A I brought the copies of the medical records of Frank Amodeo; I brought a copy of the deposition of Frank Amodeo; I brought the letter received from Shook, Hardy with respect to the medical records and deposition of Frank Amodeo; I brought a copy of my curriculum vitae; I brought a copy of the expert witness disclosure; and a form that we use in our office pertaining to what our charges are for legal review -- review of medical records for legal purposes, as well as what we charge for review of records, depositions, discussions, court appearance, etcetera.

Q And did you bring anything else?

A To the best of my knowledge, I did not.

Q Do you have a list of all litigation in which you have testified?

A I do not.

Q Do you ever advertise your services as an expert witness?

A I have never done so.

Q Do you have any financial records which would show the percentage of income you receive as an expert consultant and/or a testifying expert?

A I would say it would vary from year to year. In some instances, zero; in some instances, half a percent. In any event, less than one percent of my gross income.

Q Now, did you bring with you any medical texts or articles, trade publications, government regulations, etcetera, in response to number five on the request for information?

A Well, I would have to move to another building, probably the Library of Congress, to fully comply with that request.

Q Are there any specific textbooks or articles that you rely on as a basis for your opinions?

A No.

Q The letter from Shook, Hardy and Bacon, what does that say?

A This was sent via Federal Express to William A. Alonso, M.D., 2727 West Martin Luther King Boulevard, Suite 620, Tampa, Florida 33607; dated November 19th, 1997.

"Dear Dr. Alonso: Enclosed please find the medical records and deposition of Frank Amodeo, a class representative in the Engle case," period. "If you have any questions or need any further information, please do not hesitate to contact me. Thank you. Sincerely, M. Jane Ascheman, managing analyst."

Q Did you ever have any contact with Jane Ascheman?

A Yes. She visited with Mr. Perry from time to time when they would come to talk to me in Tampa, after my initial visit with Mr. Perry and Mr. Bajo.

Q Did she ask you any questions or did you provide any information to her?

MR. PERRY: Well, I guess I would object insofar as if you're asking about the Engle case, that's fine, but if you're asking about other cases where we were meeting with him on his review of records in other cases, I'd object and instruct him not to answer as far as other cases. But as far as the Engle case, he's more than free to go ahead and answer those questions.

A With respect to the Engle case, I did meet with Mrs. Ascheman and Mr. Perry.

Q Now, what, if anything, did Ascheman ask you or tell you?

MR. PERRY: Same objection. I would instruct the witness only to answer in regards to the Engle case.

A It -- it was in respect to my review of the medical records and deposition of Frank Amodeo.

Q What's the date of that letter?

A I believe it's -- yeah, here it is -- November 19th, 1997.

MR. HOAG: I'd just like to have that letter marked as Exhibit 1, Plaintiff's Exhibit 1.

MR. PERRY: We'll do that. We'll make a copy of it and mark it.

MR. HOAG: Thank you. The form for all -- I guess it's related to your billing that you've described, I'd like to just get that marked as Plaintiff's Exhibit 2.

MR. PERRY: All right.

MR. HOAG: And attach it to the deposition. Is that just one page?

MR. PERRY: Yes.

Q Okay. Your disclosure statement, referring to page two, says you will discuss factors which influence the accuracy of diagnosis of these diseases, meaning diseases of the head and neck.

What are those factors which influence the accuracy of diagnosis?

MR. PERRY: John, where are you reading from? I don't see that on --

MR. HOAG: Page two, next to last paragraph,

middle of the first sentence.

A This would have to do with the clinical presentation of the patient when first seen in terms of an initial impression, based on the initial visit of the complete history taking and physical, and then if it's a patient suspect for a head and neck cancer that requires biopsy, the next step would likely be diagnostic study such as an MRI scan or -- or some radiological study of equivalence, possibly a fine needle aspiration biopsy.

And when all of the diagnostic nonsurgical evaluations are completed, the final step would be to go and sample or biopsy the tumor directly, and have this studied in a hospital pathology department to finalize a written diagnosis by the pathologist before any treatment is initiated.

Q Is that -- is that pretty much all the factors which influence the accuracy of diagnosis?

A This is what I had in mind. In other words, the steps to secure a accurate and acceptable, in other words appropriate, diagnosis.

Q The first page of your disclosure statement, referring to the last paragraph, last sentence, it says, "He will further testify that the location and extent of tumor growth and invasion makes the assessment of the original site of the cancer within the head and neck organs

difficult."

In what way would that make the -- could that make the assessment of the original site of the cancer difficult?

A If it's a large cancer, it may overlap more than two regions in the hypopharynx or larynx, and this can make it difficult to decide where the cancer started, and, in essence, where it ended.

Q Well, can you narrow it down to possible areas that it started, or is there an unlimited amount of areas where it could have started?

A It's quite unlimited. You can have all variations on the extent of tumor extension and invasion, and whether it remains confined in the head and neck or has extended beyond the confines of the head and neck area. The anatomical locations are multiple and varied.

Q How frequently does it occur that the only tumors initially are in the head and neck area?

MR. PERRY: Object to the form of the question.

A What -- what you're asking is how frequent does a cancer come from another area and show up in the head and neck region?

Q No. How frequently does it occur that the only tumor, at least the only tumor at the time of diagnosis, is the tumor in the head or the neck area?

A I think that's a very difficult question to

answer. You have to be, perhaps, specific as to organ and as to histological type. For instance, you can have a melanoma in the head and neck area, and you don't find anything else, and low and behold you do a scan, and it's in the liver. This -- this is a very nasty and pathetically-aggressive cancer of the skin.

Q You don't -- you don't treat melanomas, do you?

A I do, indeed.

Q Oh, you do?

A Yes.

Q Melanomas that specifically the site is the head or the neck; is that right?

A Yes. Confined to the head and neck region.

Q When you say confined to, do you mean that's the only place the melanoma is located?

A Well, the site of presentation would have to be in the head and neck region for me to see the patient in the first place.

Q When you say the site of presentation, what do you mean?

A That's where the dark, changing mole would be located, suspicious for melanoma.

Q Okay. So if the actual site of the melanoma is at least initially in the head and neck area, that's when you would be the specialist that would be treating the patient.

A Right. That might be because the patient was referred to me by a dermatologist or a primary care physician. So I might not be the first person to see the patient; I would be consulted.

Q So when someone has a melanoma, and then they also have other forms of cancer in the head and neck area and other areas, then you're saying that it's difficult to figure out exactly where it started or what -- which cancer came first, is that what you're saying?

A Are you talking about somebody with multiple cancers at initial presentation? I'm not sure I understand your question.

Q Okay. If someone does not have multiple cancers at initial -- initial presentation, then you can be reasonably sure, as a medical doctor, of where the cancer originated, correct?

MR. PERRY: Object to the form of the question.

Q Is that correct?

A That's not always correct.

Q Is that usually correct?

A For most of the common cancers of the head and neck region, that is probably so.

Q And what are those common cancers of the head and neck region?

A As we stated earlier, the commonest cancer of the

head and neck region, other than a skin cancer such as a basal cell carcinoma, which is more common in the climate of Florida than in other places, the more significant type of cancer would likely be a squamous cell carcinoma. That's the most common, other than a basal cell cancer of the skin of the head and neck.

Q And the squamous cell carcinoma you're referring to is, in your opinion, associated with cigarette smoking; is that correct?

A Not exclusively. There are some squamous cell carcinomas that are associated with exposure to actinic rays, exposure to radiation; they can be related to bad dental hygiene; they can be related to alcohol overconsumption. There can be multiple contributing factors to a squamous cell carcinoma.

Q You said not -- not exclusively associated with cigarette smoking, correct?

A Yes. I said that.

Q But is it predominantly associated with cigarette smoking?

A Not if you're talking about a skin cancer, a squamous cell cancer of the skin. It has nothing to do with cigarette smoking.

Q What -- what squamous cell cancers do have something to do with cigarette smoking?

A The ones associated with cigarette smoking start at the lips and end in the throat.

Q And is cigarette smoking the predominant risk factor for those squamous cell carcinomas?

A It is not the only significant risk factor, or the predominant one.

Q What is the predominant one?

A I think there are several that would vie for that title.

Q What --

A And it depends on where you live. If you live in India, it's a bejel nut; if you're in Hiroshima, it might be an atomic bomb explosion; if you happen to drink a lot of hard liquor, it may well be alcohol. So this -- this is the problem. There are a lot of high risk factors; smoking is one of them.

Q What if you live in the United States and you don't drink a lot of alcohol, is cigarette smoking the predominant risk factor for those squamous cell carcinomas?

MR. PERRY: Object to the form of the question.

A It may well be with respect to the designated areas that I mentioned.

Q When you say it may well be, I'm not sure what you mean by "may well be".

A Well, I -- I don't have in my fingertips the

statistical knowledge with respect to what extent excess or inordinate use of alcoholic beverages and problems with dental hygiene contribute to the development of a squamous cell cancer. This is particularly true in the oral cavity, and this is why it's difficult to put one high risk factor on to itself.

Q That information, though, is available, isn't it?

A What information is available? I don't know what you're alluding to.

Q The information you said you don't have at your fingertips.

A Can you be more specific?

MR. HOAG: Well, we have to read back your question (sic). I was hoping you'd remember what your answer was. Can you read back his answer.

(Whereupon the court reporter read back).

MR. HOAG: Okay. You can stop there.

Q So what I was asking you is: Is that information that you don't have right now at your fingertips, is that actually readily available information that you could find?

A I could try.

Q You don't know whether or not that information is available?

A I would presume that there would have to be some information with respect to alcohol abuse and the problem of

cancer of the oral cavity, and possibly relation to oral hygiene as well, but I -- I presume that this is available, yes, and it might well be something one could try to find.

Q Have you ever tried to find it?

A No. I've had no reason to try to get a specific statistical number for any particular publication that I was involved in; in other words, this is something I was not really without -- I had no interest in doing this; in other words, it's something I was not interested in seeking.

Q And you haven't been asked to do that, have you.

A I have not been, no.

Q Have you ever reviewed or read any of the Surgeon General -- United States Surgeon General's reports as it relates to cigarette smoking and diseases of the head and neck?

A I've never read the Surgeon General's full report. I might have seen inferences to it in the lay press.

Q But you're not sure whether you've seen inferences to it in the lay press?

A I think I probably have, or listened to it on CNN, one of the national television networks. I don't doubt that I probably have.

Q But other than hearing news reports or reading newspaper accounts, you haven't reviewed or read any of those Surgeon General's reports that are related to

cigarette smoking and cancers of the head and neck; is that correct?

A I have never received nor read the verbatim, official Surgeon General's report, no.

Q What are your current duties at the university?

A I am a member of the clinical staff in the department of otolaryngology, and I, on a part-time basis, supervise the medical students and residents in training both at the James V. Haley Veteran's Hospital, as well as at the medical school. I also occasionally give lectures and participate in the academic development of the medical students and residents.

Q Do you have a private practice?

A Yes.

Q And have you been in private practice ever since -- well, how long have you been in private practice?

A Since 1975.

Q And your specialty area is cancers of the head and neck?

A The Board Certification that I have is in otolaryngology, and the name of the academy I belong to is the American Academy of Otolaryngology and Head and Neck Surgery.

Q And what does that word mean, "otolaryngology"?

A Oto means ear; the l-a-r part has to do with the

larynx, with the throat. It is sometimes called otorhinolaryngology, the "rhino" meaning nose.

Q And how many patients do you see on the average each year?

A You mean overall?

Q Yes, I do.

A I probably see 80 patients, at least, a week, and it's -- it's probably in the realm of four thousand. That would be my guess. That's strictly a guess.

Q What percentage of your patients have squamous cell carcinomas that are associated with cigarette smoking?

A I would have to venture a guess. Head and neck cancer is a rare disease. I would have to first think about how many patients with head and neck cancer I see -- this would include the full gamut of tumor patients -- and I would then have to break down how many were squamous cell cancers from the lips to the throat, and then look at those and figure out how many had a social habit of cigarette smoking or overindulging in cigarette smoking.

If you -- if you were to look at those, it would certainly be at least 60 to 70 percent of the group that we mentioned from the lips to the throat that have squamous cell cancers.

Q At least 60 or 70 percent of them were smokers?

A Yes. Of one sort or another. As I say,

cigarettes being the most common. But that would also include, in the area where I live, where there's been a very strong cigar industry, it would include patients that have never used cigarettes, but did use cigars. It would include patients that chew tobacco, etcetera.

Q And what -- in numbers, what percentage of your patients have this disease, whether or not they're smokers?

A I'm not sure I follow your question.

Q Okay. I'll try to rephrase it. You estimated that you see about four thousand patients per year, correct?

A That's a guesstimate.

Q All right. Of those estimated four thousand patients per year, how many of them, regardless of whether or not they're smokers, how many of them have head or neck cancers that have been associated with cigarette smoking?

A This would be somebody who was not a smoker themselves, but were in a context where others are smoking around them; is that what you're saying?

Q No. What I'm asking for is the number of patients who have the -- that you see each year who have squamous cell carcinomas of the head or neck area, which would be, you know, from the lips down, as you've described it.

A Which ones would not have smoked; is that what you're saying?

Q No. How many total of the -- of the four thousand

patients, how many of those four thousand had or have that particular -- or those particular diseases, squamous cell carcinomas of the head or neck?

A Okay. So what you want to know is how many I would have seen in my office or at the medical school in the course of a year that have squamous cell cancers from the lip to the throat; is that correct?

Q Yes.

A I would guess somewhere in the range of two to four a month; total of somewhere around 50. Might be less than that, and might be more, depending on the year.

Q Okay. In your estimate of those approximately 50 people per year, at least 60 or 70 percent of them are smokers.

A Would have a tobacco-related history.

Q And you don't know whether it's higher or not because you haven't really looked and analyzed those numbers statistically, correct?

A That is right.

MR. PERRY: And I would object to the form of the question.

Q Now, those patients who have those specific squamous cell carcinomas who are smokers, do you advise them to stop smoking?

A Yes, I do.

Q And are most of those people who are smokers cigarette smokers?
A I would say so, yes.
Q Why do you advise them to stop smoking cigarettes particularly?
A I said earlier in my deposition that I consider it a significant risk factor.
Q Okay. If they stop smoking, do they have a better prognosis for the disease?
A It depends of the stage of the disease when it's first identified. If it's very advanced, it probably makes no difference.
Q If it's not very advanced, does it make a difference if they stop smoking cigarettes?
A If they have a chance of being treated with a reasonable chance of survival, which is what we all strive for, I definitely encourage them not to smoke. It interferes with their treatment course, as well as their prognosis, as far as I'm concerned.
Q In what way does it interfere with their prognosis, as far as you're concerned?
A It can interfere with wound healing; it can lead to complications pertaining to their treatment; it can cause them to become less able to cope with their cancer.
Q Does it ever cause the cancer to further progress

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than it would otherwise have progressed had they stopped smoking?

A I don't know.

Q Do you have an opinion based on your observation over the past 22 years?

MR. PERRY: Object. Asked and answered. He said he didn't know.

Q Do you have an opinion based on your observation of these patients over the past 22 years?

MR. PERRY: Same objection.

MR. HOAG: You can answer.

A I think if it's the patient who has, as I stated earlier, a very advanced cancer when first seen, it has zero to do with whether they're going to survive or not. In other words, the damage is done, and it makes no difference.

If it's a patient who has a reasonable chance of being cured, I feel that their ability to cope with the disease, to be less prone to the disease, is increased by not smoking. I feel that they do better if they do not smoke.

Q So the progression of the disease is less likely to occur if they stop smoking; is that correct, in your opinion?

MR. PERRY: Object to the question. That's not his testimony. You're misstating --

Q Doctor, is that your opinion?

MR. PERRY: Excuse me?

Q Is that correct, in your opinion, sir?

MR. PERRY: Same objection.

MR. HOAG: You can answer.

A With the parameters that I discussed, yes.

MR. HOAG: I don't have any other questions. It's about 4:00 right now. I hope everyone has a happy new year. I hope you had a good holiday so far, and thank you very much for your time.

MR. PERRY: Thank you, John. We will read and sign.

MR. HOAG: Okay.

(Whereupon, the deposition concluded at 3:50 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, the undersigned authority, certify that WILLIAM A. ALONSO, M.D. personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 5th day of January, 1998.

TAMMY J. MILCOWITZ, RMR
Notary Public - State of Florida
My Commission Expires: 2/17/99

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STATE OF FLORIDA)

COUNTY OF HILLSBOROUGH)

I, TAMMY J. MILCOWITZ, RMR, certify that I was authorized to and did stenographically report the deposition of WILLIAM A. ALONSO, M.D.; that a review of the transcript was requested; and that the transcript is a true and complete record of my stenographic notes.

I further certify that I am not a relative, employee, attorney, or counsel of any of the parties; nor am I a relative or employee of any of the parties' attorney or counsel connected with the action; nor am I financially interested in the action.

WITNESS my hand and official seal the 5th day of January, 1998.

TAMMY J. MILCOWITZ, RMR
Notary Public
State of Florida at Large
My Commission Expires:
February 17, 1999

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DEPOSITION EXHIBIT

NOT RECEIVED

DEPONENT: William A. Alonso

CASE NAME: Howard A. Engle

EXHIBIT NO: # 1 + # 2

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